Guia #10
Unidad de Información y Asistencia

COMO PRESENTAR UNA APLICACION DE ADJUDICACION DEL RECLAMO

Debe llenar este formulario para poder establecer un caso con la "Junta de Apelaciones de Reclamos de Compensación de Trabajadores" (Workers' Compensation Appeals Board).

Por lo general se utiliza este formulario cuando existe una disputa que no se puede resolver de manera informal.

Llene el formulario y siga las instrucciones que se encuentran al respaldo.

Por favor tenga en cuenta que no se le dará una audiencia hasta que no presente el formulario una Declaración de Prontitud a Proseguir con su caso. a la guía #07.

Los documentos que se mencionan a continuación deben ir incluídos con la aplicación ya llena por completo.

(1) Una copia de la Petición del Empleado para Beneficios del Trabajador. (Se requiere el formulario solamente para las lesiones que tomaron lugar entre las fechas del 1ro de enero de 1990 y el 31 de diciembre de 1993. efiérase a la guía #01.

(2) Una declaración de acuerdo con el Artículo 4906(g) del Código Laboral, vea el adjunto.

Le recomendamos que retenga un comprobante de notificación, vea el adjunto.

Envíe el formulario original a la "WCAB"y una copia del formulario a la compañía de seguros.

Retenga una copia del formulario para su propio archivo.

Si requiere ayuda, puede llamar a una de las oficinas de "Información y Asistencia". Los números de teléfono para las oficinas locales se encuentran listados al respaldo.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92801
1661 N. Raymond Avenue, Ste. 200 (714) 738-4038
Information & Assistance Unit

BAKERSFIELD, 93309
1800 30th Street, Rm.100 (661) 395-2514
Information & Assistance Unit

EUREKA, 95501-0421
100 "H" Street, Rm. 201 (707) 441-5723
Information & Assistance Unit

FRESNO, 93721-2280
2550 Mariposa Street, Rm. 4078 (559) 445-5355
Information & Assistance Unit

GOLETA, 93117
6755 Hollister Avenue (805) 968-4158
Information & Assistance Unit

GROVER BEACH, 93433-2261
1562 Grand Avenue (805) 481-3296
Information & Assistance Unit

LONG BEACH, 90802-4460
300 Oceangate Street, 3rd Floor (562) 590-5240
Information & Assistance Unit

LOS ANGELES, 90013
340 West 4th Street, 9th Floor (213) 576-7389
Information & Assistance Unit

OAKLAND, 94612
1515 Clay Street, 6th Floor (510) 622-2861
Information & Assistance Unit

POMONA, 91766
435 W. Mission Blvd., Suite 300 (909) 623-8568
Information & Assistance Unit

REDDING, 96001-2796
2115 Akard, Rm. 21 (530) 225-2047
Information & Assistance Unit

RIVERSIDE, 92501
3737 Main Street, Ste. 300 (909) 782-4347
Information & Assistance Unit

SACRAMENTO, 95825
2424 Arden Way, Ste. 230 (916) 263-2741
Information & Assistance Unit

SALINAS, 93906
1880 North Main Street, 1st Floor (408) 443-3058
Information & Assistance Unit

SAN BERNARDINO, 92401-1888
464 West Third Street, Ste. 239 (909) 383-4522
Information & Assistance Unit

SAN DIEGO, 92101-3690
1350 Front Street, Ste. 3012 (619) 525-4589
Information & Assistance Unit

SAN FRANCISCO (DISTRICT OFFICE), 94102
455 Golden Gate Ave., 2nd Floor (415) 703-5020
Information & Assistance Unit

SAN JOSE, 95113
100 Paseo de San Antonio, Rm. 223 (408) 277-1292
Information & Assistance Unit

SANTA ANA, 92701-4080
28 Civic Center Plaza, Ste. 451 (714) 558-4597
Information & Assistance Unit

SANTA MONICA, 90405-5200
2701 Ocean Park Blvd., Std. 222 (310) 452-1188
Information & Assistance Unit

SANTA ROSA, 95404
50 "D" Street, Ste. 430 (707) 576-2452
Information & Assistance Unit

STOCKTON, 95202-2314
31 East Channel Street, Rm. 417 (209) 948-7980
Information & Assistance Unit

VAN NUYS, 91401-3373
6150 Van Nuys Blvd., Rm 105 (818) 901-5374
Information & Assistance Unit

VENTURA, 93003-6085
5810 Ralston Street, Rm. 115 (805) 654-4701
Information & Assistance Unit

WALNUT CREEK, 94598
175 Lennon Lane, Rm. 200 (925) 977-8343
Information & Assistance Unit

As of May 18, 2000

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

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CASE No.

APPLICATION FOR ADJUDICATION OF CLAIM

(Print or Type Names and Addresses)

M Su nombre

Social Security No.: Su número de seguro social

su dirección completa
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

dejeeste espacio en blanco
(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

(APPLICANT'S ADDRESS AND ZIP CODE)

nombre del empleador
(EMPLOYER - STATE IF SELF-INSURED)

dirección del empleador
(EMPLOYER'S ADDRESS AND ZIP CODE)

nombre de la compañía de seguros
(EMPLOYER'S INSURANCE CARRIER, OR, IF SELF-INSURED, ADJUSTING AGENCY)

dirección del seguro
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born fecha de nacimiento (DATE OF BIRTH) while employed as a ocupación al tiempo del accidente (OCCUPATION AT TIME OF INJURY)
   on fecha del accidente (DATE OF INJURY) at dirección donde ocurrio el accidente (ADDRESS) (CITY) (STATE) (ZIP CODE)
   By the employer sustained injury arising out of and in the course of employment to
   partes del cuerpo que se lesióno
   (STATE WHAT PARTS OF THE BODY WERE INJURED)
2. The injury occurred as follows: que estaba haciendo cuando se accidento
   (EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: Salario semanal o mensual y horas que trabaja por semana
   (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
   declaré el valor por semana o mensual de todas ganancias incluyendo propinos
   (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: fecha del último día que trabajo por razón del accidente
   (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid ____ (YES) ____ (NO) $____ (TOTAL PAID) $____ (WEEKLY RATE) fecha del último pago del seguro (DATE OF LAST PAYMENT)
6. Unemployment Insurance of unemployment compensation disability benefits have been received since the date of injury
   ____ (YES) ____ (NO)
7. Medical treatment was received ____ (YES) ____ (NO) fecha de su última cita con el médico (DATE OF LAST TREATMENT) All treatment was furnished by the employer or Insurance Company____ ____ Other treatment was provided or paid by nombre de persona o agencia proveyendo o pagando por tratamiendo medico (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim
   ____ (YES) ____ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are nombre y dirección del medico o hospital que no fue pagado por el seguro
   (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
8. Other cases have been filed for industrial injuries by this employee as follows: otros casos de accidentes de trabajo que este empleado tiene son:
   (SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity____
   Permanent disability indemnity____ Reimbursement for medical expense ____ Medical treatment ____
   Compensation at proper rate ____ Rehabilitation ____ Other (Specify) ____ AND APPLICANT REQUESTS A HEARING AND AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at ciudad (CITY), California fecha de hoy (DATE)

____ (APPLICANT'S ATTORNEY)

X su firma (APPLICANT'S SIGNATURE)

____ (ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

DIA WCAB FORM 1 (REV 7/81)

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM

CASE No. _____

(PRINT OR TYPE NAMES AND ADDRESSES)

M _____ _____ (INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: _____ _____

_____ (APPLICANT, IF OTHER THAN INJURED EMPLOYEE) _____ (APPLICANT'S ADDRESS AND ZIP CODE)

VS.

_____ (EMPLOYER--STATE IF SELF-INSURED) _____ (EMPLOYER'S ADDRESS AND ZIP CODE)

_____ (EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY) _____ (INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a _____ (OCCUPATION AT TIME OF INJURY)
   on _____ (DATE OF INJURY) at _____ (ADDRESS) (CITY) (STATE) (ZIP CODE)
   By the employer sustained injury arising out of and in the course of employment to
   _____ (STATE WHAT PARTS OF THE BODY WERE INJURED)
2. The injury occurred as follows: _____ (EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: _____ (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
   _____ (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: _____ (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid ____ (YES) ____ (NO) $_____ (TOTAL PAID) $_____ (WEEKLY RATE) _____ (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
   ____ (YES) ____ (NO)
7. Medical treatment was received ____ (YES) ____ (NO) _____ (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ____ (YES) ____ (NO) Other treatment was provided or paid by _____
   _____ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim ____ (YES) ____ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are _____ (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
8. Other cases have been filed for industrial injuries by this employee as follows: _____
   _____ (SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity _____
   Permanent disability indemnity _____ Reimbursement for medical expense _____ Medical treatment _____
   Compensation at proper rate _____ Rehabilitation _____ Other (Specify) _____

_____ AND APPLICANT REQUESTS A HEARING AND AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ (CITY), California _____ (DATE)

_____ (APPLICANT'S ATTORNEY) _____ (APPLICANT'S SIGNATURE)

_____ (ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS (DIA/WCAB Form 9) IS PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendants named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Industrial Accidents.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney fee will be set by the Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

All blanks in the application shall be completed. Where the information is unknown, place "unknown" in the blank. If *medical treatment is paid for by Medi-Cal, Medicare, group health insurance or private carrier, please specify.*

Service of Documents

Your attorney or agent will serve all documents in accord with Labor Code Section 5501 and Section 10500 of the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the office of the Workers' Compensation Appeals Board.

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of Su condado California. I am over the age of eighteen years, my (business/residence) address is:

la dirección de su residencia

On fecha de hoy, I served the attached Petición de mala conducta on the empleador in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at ciudad desde le envió addressed as follows

nombre y dirección del empleador

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) fecha de hoy, at ciudad California.

Type or print name escriba su nombre

Signature X su firma

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: _____

_____
Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."